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NOTES ON APPENDICITIS.

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In his paper on appendicitis, read before the Rochester Pathological Society (*New York Medical Journal*, November 10, 1906), Dr. W. D. Ward reports several cases of Koch, Sheen, Eisendrath, and others where abscesses in and near the liver and in other parts of the body were found due to the delay in the operation for appendicitis. That this occurrence is not so very rare is shown by the following two cases with delayed operation where abscesses were found in other parts of the abdomen.

Case I.—In the first case of a young girl, 19 years of age, I was called in consultation on the ninth day of her sickness, May 30, 1905. The family physician reported that when he first saw the patient, nine days previously, he found her in great distress with high temperature, frequent pulse and severe pain in the cæcal region. His diagnosis was suppurative appendicitis, and he waited for the abscess to be walled off from the general cavity before recommending an operation. I found the patient in a very serious condition, with frequent, feeble pulse, high temperature and intense rigidity of the lower abdomen. I, therefore, advised an immediate operation. Two hours later on opening the peritonæum about a pint of thick fœtid pus gushed out. The appendix was found gangrenous, about two thirds having been dissolved by decay. The rest of the appendix was now removed, the wound drained with a rubber tube and gauze and left wide open. After two months the wound closed and the patient left her sickbed.

Fourteen months later the patient took sick again with pain in the lower abdomen. The examination per rectum, the girl supposed to be a virgin, revealed a mass in the Douglas's pouch. This time I recommended her to go to the hospital, and July 14, 1906, I opened the posterior vault of the vagina, and about half a pint of pus rushed out. I drained the wound with two rubber drains. Two weeks later the patient left the hospital cured.

Case II.—The second case was a boy eighteen years old. He took sick with pain in the back on the right side and in the right epigastrium, four weeks previously, and was treated all this time for rheumatism. His condition did not improve, on the contrary the sensitiveness spread all over the right side. Another physician was then called in who made the diagnosis of appendicitis and sent the patient to the hospital.

At the examination the entire abdomen was found very sensitive and rigid, especially in the lumbar region extending as far as the cartilage of the twelfth rib and down to the iliac bone. The temperature was 102°, the pulse 108.

On the 30th of June, 1906, the patient was operated upon. On opening the peritonæum the omentum was found to wall off the front of the abscess and I had to ligate and remove a part of it to reach the abscess, which extended from the cæcum to the vault of the diaphragm beneath the liver. The entire appendix had decayed. No more than a piece of the organ, one centimetre long, was left which with the cæcum, omentum, and the loops of the other intestines formed one ulcerated mass. This mass walled off the abscess against the pelvic cavity.

The cavity of the abscess was flushed with normal salt solution and drained with gauze, which was put as high as the diaphragm. Only one suture was put in the lower angle of the wound to keep the intestines from bulging forward. In the first two days after the operation the temperature and pulse went down, but the meteorism increased. The wound was cleansed daily with hydrogen peroxide. On the fourth day diarrhœa set in and kept on until the patient died two days later.

No doubt in this case the abscess between the liver and diaphragm was caused by the delay of the operation for appendicitis, while in the first case the abscess in Douglas's pouch, fourteen months after the operation in an unmarried girl without any specific history may or may not be the result of the former appendicitis.

Now, these two cases would tend to show the desirability of an early operation. Still I cannot reconcile myself to the justice of the remorse Dr. Ward felt for having administered morphine and not having operated sooner upon his patient with severe pain in the epigastrium without tenderness or rigidity, with a pulse of 80 and temperature of 98.4°. I fail to see how he could have acted otherwise than relieve the pain and await developments. The case showed in the beginning less severe symptoms than any case of an everyday bellyache. Thousands of similar cases occur daily without the services of a physician being invoked, and general practitioners see daily hundreds of such cases without ever dreaming to call in a surgeon and submit their patients to a dangerous operation. If in Dr. Ward's unfortunate case, as it later turned out, an immediate operation was needed, that does not say that every bellyache needs one. Because we are not able to make the differential diagnosis between a simple every day indigestion and suppurative appendicitis in a great number of cases, our ignorance ought not to serve us as an excuse to open every painful abdomen in search for appendicitis. How easily a mistake in the diagnosis may be made is shown by the following two cases:

Case III.—A medical student was suddenly taken sick on the street and had to be brought home in a cab. The pain in the cæcal region grew worse even after he had taken calomel and had had several good movements. I was called in the middle of the night and when I en-

tered the sick room the patient himself had his diagnosis cut and dry and greeted me with the words: "Doctor, I have appendicitis." The pulse was 110; temperature 102° F., and sensitiveness over the appendix, i. e., a classical case of appendicitis. Since the patient had already taken calomel, and I did not think the case required an immediate operation in the middle of the night with all the inconveniences at that time I decided to wait until the following morning, and gave the patient in the meantime some opium to relieve the pain. The next morning the patient went to college as usual. He is now a practicing physician here in the city for the last seven years, and is still waiting for his operation.

Case IV.—The other case, pertinent to the subject in question that I wish to relate, is that of a young lady of eighteen years of age, who took sick with pain in the cæcal region. When I called on her the next day I found the region so sensitive that I could not touch it without evoking the most excruciating pains. Hence, the rigidity could not be tested. The temperature was 101° F., the pulse 100. She had taken cathartics with very good results. So I ordered ice on the abdomen and opium internally. Three days later she was well and out of bed. A month later I was called again and found the patient in bed with the same symptoms. I followed the same treatment with the same result. But this time my suspicion was directed upon the genital tract and I began to inquire about her genital functions. I was informed that the former as well as the present attack occurred just a few days before her menstruation. I then advised the patient to be treated with electricity, and a few days later she came to my office for this treatment. The cæcal region was still very sensitive to the touch of the finger when her attention was called to the examination, but I could press the electrode as much as I wanted, and she did not notice it. I then tried the experiment to press with the finger at the sensitive point while diverting her attention by conversation. This time the pressure of the finger also passed unnoticed. My diagnosis was now "antimenstrual neuralgia of the right ovary in a somewhat hysterical person," and I informed my pa-

tient in this sense. The result of my candor was that the next month when she again got her attack another physician was called in, and the patient was immediately taken to a hospital and operated upon. A healthy appendix was removed, and the patient still had her monthly attacks, until she got married.

These two cases, among many others, may best serve as an example of the diagnostic difficulties in appendicitis. With all my precaution since I began to devote myself exclusively to abdominal surgery I have still removed quite a few healthy appendices, and the presence of the colon bacillus within them which often serves as an excuse for the removal of an otherwise normal appendix, did not console me in the least. The bacillus being the usual inhabitant of the healthy colon has a perfect right to have its residence in the healthy appendix. In such cases I had always the impression of having uselessly subjected my patients to the dangers of a laparotomy, owing to the impossibility of an exact diagnosis. And I am not alone in this respect. I was present in Hôpital St. Louis in Paris when Richelot opened the abdomen and found a healthy appendix; I was present in the Red Cross Hospital in Munich when Schmidt opened an abdomen and removed a normal appendix, and I was present when the late Mundé, in Mount Sinai Hospital, opened the abdomen and found a healthy appendix. These were and are men with great diagnostic acumen, yet they found conditions they did not expect before the operation.

Therefore, it seems to me, that as long as we surgeons are not always able to make the differential diagnosis between a common bellyache and suppurative appendicitis, as long as we are at a loss to differentiate between gravel in the right ureter and appendicitis, typhoid fever and appendicitis, fæcal impaction in the cæcum and ap-

pendicitis, gallstones and appendicitis, ovarian neuralgia and appendicitis, colitis and appendicitis, etc., we have no right to assume the airs of superiority and scold the general practitioner for not calling us in consultation in every case of bellyache, and lecture our fellow surgeons for having different opinions than ours in regard to the best time for the operation. The conservative surgeon has a perfect right to his claim that in the long run he can show the same amount of success as the radical. The latter may, through an early operation, save a patient whom the conservative surgeon would have lost through his waiting for the diagnosis to become clear. But the conservative surgeon will subject fewer patients to the unnecessary dangers of a laparotomy and to all its sequels. This has been proved by a statistical study of cases of appendicitis made by Dr. Chauvel, the medical inspector of the French army. In 1902, 668 patients apparently suffering from appendicitis were received in the military hospitals of France. Out of this number 188 were treated according to the surgical rite and 480 received purely medical treatment. Of the number operated upon 23 died, while out of the 480 not operated upon there were but three deaths.

Hence, what we need are not lectures when to operate and how to operate in appendicitis, but good instruction to increase our diagnostic skill. As long as the best of us, through the limitations of our medical science not our own fault, may confound appendicitis with a simple bellyache we ought to devote our energies to discover reliable pathognomonic characteristics of suppurative appendicitis. When we will have discovered these desirable pathognomonic signs and they have become common property of the medical profession then, and not until then, will the general prac-

titioner send every appropriate case to the surgeon, and there will be no difference of opinion among the surgeons themselves, when to operate and how to operate.

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